EDITORIAL

The informationist—two years later

The participants generally agreed that the word was inelegant, but we all kept using it anyway, as if the acknowledgment released us from the search to find something better. As we bandied it about, one might have thought it had been in general parlance for years, rather than being a recent coinage invented to try to gather loosely together a set of concepts for exploration. Now that the conference on ''The Informationist'' is over, do we have a better idea of what the informationist is? I think we do. At least, I think we have a better understanding of some of the ideas involved.

This issue of the *Journal of the Medical Library Association (JMLA)* contains a brief overview of the conference, which was sponsored by the Medical Library Association (MLA) and held at the National Library of Medicine (NLM) in April of 2002 [1]. I encourage you to spend some time with the conference Website* as well. Many of the presentations have been posted there, as well as a conference summary and the transcript from the online chat session that took place several weeks later. The MLA Board of Directors has asked the task force to continue to work on options for further developing the concept, and additional information will continue to be posted to the Website.

I am sure that all of the participants came away with their own handful of highlights; here I intend to offer just a few of my own. One of the things that struck me early in the first day was that we seemed to implicitly assume that we were talking about potential extensions of roles for librarians. This assumption surprised me somewhat, because I took the original Frank Davidoff and Valerie Florance editorial to be neutral about the possible backgrounds of individuals filling the informationist role [2]. But while some of the presenters and some of the discussion touched on the notion of entrants to the field from other arenas, we always came back quickly to librarians.

As a member of the task force that organized the conference, I recall that in our early planning documents we envisioned a very wide-ranging attendance, with representatives from all across the health care spectrum. And, in fact, a number of individuals representing other professionals attended, and they had a great deal to contribute. Still, as we sat in NLM's Lister Hill Center auditorium, the audience was overwhelmingly librarians. We were among the true believers. Librarians and nonlibrarians alike, this was a group who did not need any convincing that we needed to do a better job of managing information in the health care and biomedical research arenas. The discussion focused on whether or not ''informationists'' represented the avenue toward making things better.

As I see it, the central notion of the pro-informationist argument is that the effective management of information resources requires an individual who has formal training of some sort both in information management and in the particular discipline—a true hybrid. Implicit in this is that one could come to this role from a variety of areas. Some librarians bristled at the notion that ''retired clinicians'' might be easily trained to perform the informationist role. Yet it strikes me that there is an incongruity between that reaction and the notion that librarians can start participating effectively in rounds with little or no formal clinical training. A conceptual gap remains that requires more exploration.

This issue of education and training is critical, because it is the touchstone of concern among some hospital and clinical medical librarians. Michael Kronenfeld, in his National Network article (which was referred to several times by participants), charged that the Davidoff and Florance editorial was a direct attack on hospital librarians [3]. While this was certainly not the intent (and Davidoff and Florance reconfirmed that in their presentations at the conference), it is also clear that many hospital librarians saw the same red flags. The perception among these concerned librarians is that the editorial suggests that they are not qualified to deliver the sorts of services being described, and that this suggestion implies that they need to be replaced by the dreaded ''informationists.'' The rejoinder from these librarians might be, ''The services that are being described are precisely those that we are *already* providing. Rather than creating a new profession, we need to focus on providing better support for what medical libraries are already doing.''

One might respond to this in a couple of ways. For one thing, informationists are not the be-all and end-all of information services and need not be in competition with librarians. In some cases, what librarians do is what the informationist would be called to do, but even if there were large numbers of well-trained and qualified informationists, that would not eliminate the need for professionals doing all the other things that librarians do. Not all hospital librarians are or need to be clinical medical librarians (CMLs) in the ways in

* The conference Website may be viewed at http://www.mlanet.org/research/informationist/.

which we have understood the term over the past thirty years.

However, that begs the question in an important way, because a central part of the informationist argument is that what is needed is not, in fact, what is already being done. Without some degree of specialized training, such as is not typically acquired by librarians, an individual is not qualified to provide the level of services described under the term ''informationist.'' Moreover, until the funding and organizational status of that individual are changed and moved out of the library and into the clinical departments, even well-trained individuals will not be effective in the way the editorial envisions. This proposition was not directly confronted during the conference, but it hovered in the background during all of our discussions.

Start with the question, do current CML programs effectively meet the information management needs of clinical care? One answer to this might be, yes, they do, in the institutions in which they are well developed. If that is the case, then the next question becomes, why, in thirty years, have they not become the norm? In his keynote remarks, Davidoff put this question in the context of diffusion of innovation theory, discussing the patterns by which new ideas move through a society. First, they are presented by the innovators themselves, then are picked up by the early adopters, and gradually move into the mainstream. With clinical medical library services, we are still largely in the early adopter stage, and the question remains, why have they not moved into the mainstream?

Part of what distinguishes early adopters from the mainstream is the early adopters' willingness to take innovations on faith. Something looks like it might be a good thing, so the early adopters are willing to try it out. The mainstream requires more proof. They want evidence that the investments of time and energy and resources are going to have a payoff in the areas that they care most deeply about. In health care, the payoffs are pretty clear—shorter length of stay, fewer unnecessary tests, fewer adverse effects, fewer medication errors, and the like. To move clinical librarian or informationist, or whatever you want to call them, services into the mainstream will require demonstrating a closer connection between those services and these desirable outcomes.

The Davidoff and Florance editorial goes further than this, though. Implicit in their argument is the notion that proving the value is not enough. Not only do librarians have to get out of the library physically (as clinical medical librarians do now), but they have to get out of the library organizationally. They need to be employed by, and responsible to, the clinical departments. Only then will the funding and acceptance challenges be successfully met. But participants at the conference suggested that other ways to address these issues might exist that would retain the base in the library.

There were several references, for example, to ongoing projects at the Eskind Biomedical Library at Vanderbilt University. The work being done there is well documented† and shows a commitment to training and organizational ingenuity that provides a useful point of comparison to other attempts to establish strong CML programs. I think that perhaps the most significant thing about the Vanderbilt program is simply the radical notion that putting librarians into the clinics is the top priority. Too often, library directors have seen these programs as extras. If, after all our other priorities have been met, we can find a way to fund a CML program, then we might do it. But because we never have enough funding to do everything we would like to do, CML programs fall to the bottom. At Vanderbilt, because it is a top priority, it gets funded at the top of the library budget. This notion is radical, because it upends the standard models and requires considerable shifting of job assignments within the library, but it is a beautifully simple approach toward solving the tangled problem of funding CML programs.

How much of this can be transferred to other institutions is still a big question, however, as Nunzia Giuse, the Vanderbilt library director, pointed out during one of the question-and-answer periods. The institution must be culturally and organizationally ready to embrace such an approach. Other institutions may not find such a rearrangement of priorities to be feasible.

One of the things apparent from the conference is that a great deal of innovative work is going on. There are many successful programs in hospitals and medical centers throughout the world. But how many of these are documented? Two years ago, in the *Bulletin of the Medical Library Association,* Carolyn Lipscomb traced the history of clinical medical librarianship as reflected in the library literature [4]. At the conference, K. Ann McKibbon announced her intention to write a systematic review of these efforts. The systematic review will be tremendously helpful, but it will only identify what has so far been documented. There is a critical need to do more documentation and to encourage people providing these services to do sound evaluations and get them into print. This could be a valuable joint project for the Hospital Libraries and the Research Sections of MLA—to identify programs and to help the people running those programs to evaluate and publish.

† See, for example: GIUSE NB, KAFANTARIS SR, MILLER MD, WILDER KS, MARTIN SL, SATHE NA, CAMPBELL JD. Clinical medical librarianship: the Vanderbilt experience. Bull Med Libr Assoc 1998 Jul;86(3):412–6.

By the second day, as we continued to struggle with concise definitions, we talked of the ''thousand flowers'' approach—the notion that loose definitions were fine and that we needed to support a multiplicity of methods and models for enhancing information services at the point of need. (The phrase, by the way, is most commonly attributed to Mao Zedong, who took it from an ancient Chinese poem. He used the phrase supposedly to encourage constructive dissent, although some have suggested his real intention was to root out and eliminate the dissenters. I will refrain from commenting on whether this has any implications for the current discussion.)

It was apparent that informationists could operate in many different ways in different settings, and consensus seemed to be growing that this could be a good thing. Rather than trying to define the notion too tightly, it might be better to support a lot of different sorts of projects and see which ones are successful. (I remain somewhat concerned, however, that employing the term that loosely may result in our using a word that actually has relatively little useful meaning. If ''informationist'' can mean anything I want it to mean, how can I be sure that you and I are both talking about the same thing when we use it?)

The best outcome of the conference, of course, is simply that it took place. We are now engaged in a national discussion about how specialized information services in clinical and research settings can best be provided and what the key roles of librarians in that milieu should be. If the results of this are better training programs, improved funding, and more effective organizational models, we will all be better off.

I was talking with my mother the other day. She is in her early seventies and in good health, but she is at that age where she has to deal with the health care system on a regular basis. It is frustrating, because what she needs most of all is information, and that can be difficult to get. We discussed some of the changes that are happening within the system, the increasing emphasis on problem-solving and communication skills for medical students and the growing recognition that what physicians and other health care workers need is to be able to find and process information. The evening after finishing this editorial, I will speak to a first-semester library school class about medical librarianship. I am going to make the point that what makes our specialty different from all of our librarian colleagues' is that ours is literally a matter of life and death. At the end of the day, this is what ties us together as health sciences librarians.

The symposium on the informationist in the January 2002 issue of the *JMLA* stressed the need to be ''patient-centered'' [5]. These days, when I center on a particular patient, I think of my mother. I think of the young doctor or nurse or therapist who is trying to give her the right kind of care. I think of their information needs, and I hope we are building systems of people, machines, and networks that are getting them exactly the information they need as efficiently as possible. In my professional heart, I hope their information-providing partners are called librarians, but as my mother's son, I simply want them to be called excellent.

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